U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 10 May 2006

In the Matter of:

ROY MICHAEL VEST,
Claimant,

v.

EASTERN ASSOCIATED COAL CORPORATION,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

CASE NO: 2003 BLA 5765

Appearances: Frederick K. Muth, Esquire
For the Claimant

Paul E. Frampton, Esquire
For the Employer/Carrier

Before: Edward Terhune Miller
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Black Lung Benefits Act ("the Act"), 30 U.S.C. § 901, *et seq.* In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a formal hearing. Claimant, Michael Roy Vest, filed this claim after January 19, 2001, so it is governed by 20 C.F.R. Part 718 (2004).[1] This claim is governed by the law of the United States Court of Appeals for the Fourth Circuit since the Claimant's last coal mine employment occurred in West Virginia. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-202 (1989) (*en banc*).

[1] All cited regulations refer to Title 20, Code of Federal Regulations, unless otherwise indicated, and are cited by part or section only. The following abbreviations will be used as citations to the record: "CX" for Claimant's Exhibits, "DX" for Director's Exhibits, "EX" for Employer's Exhibits, and "Tr." for the Hearing Transcript.

ISSUES

1. Whether Employer is the responsible operator?

2. Whether Claimant has pneumoconiosis as defined by the Act and regulations?

3. Whether the pneumoconiosis, if proven, arose out of coal mine employment?

4. Whether Claimant is totally disabled?

5. Whether Claimant's total disability, if proven, is due to pneumoconiosis?

PROCEDURAL HISTORY

Claimant filed an application for benefits on May 16, 2001. DX 1. The Director, Office of Workers' Compensation Programs, awarded benefits on December 31, 2002. DX 37. On January 16, 2003, Employer/Carrier requested a formal hearing before an Administrative Law Judge. DX 40.

A formal hearing was conducted in Bluefield, West Virginia on January 12, 2005, at which time all parties were afforded a full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder, found at Title 20, Code of Federal Regulations. During the hearing, Claimant's Exhibit 1, Director's Exhibits Numbers 1 through 44, and Employer's Exhibits Numbers 1 through 7 and A were received in evidence. Tr. 6, 8, 23, 24. All of this evidence has been made part of the record.

At the conclusion of the hearing, the parties were offered an opportunity to submit written closing arguments. Tr. 29. Employer and Claimant filed written closing arguments.

FINDINGS OF FACT AND APPLICABLE LAW

Background

Claimant was born on June 6, 1953. DX 1. Claimant stated that he had 22 years of coal mine employment. *Id.* The Director found that Claimant's coal mine employment totaled 17 years. DX 37. Claimant's employment and Social Security records indicate that his coal mine employment totaled approximately 18 years. DX 5. Claimant retired in 1997. *Id.*

Applicable Law

Under § 718.203(b), a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, may invoke a rebuttable presumption that the pneumoconiosis arose out of such employment. Because Claimant has approximately 18 years of coal mine employment, if Claimant proves the presence of pneumoconiosis, he can invoke the presumption.

MEDICAL EVIDENCE

Chest X-Ray Evidence[2]

Ex. No.	Physician	B-Reader /BCR[3]	Date of X-Ray	Film Quality	Reading
EX 1	Gaylor	B-Reader/ BCR	1/9/02	2	No CWP
DX 15	Forehand	B-Reader	1/16/02	2	1/1; q/s
EX 4	Wheeler	B-Reader/ BCR	1/16/02	1	No CWP
DX 36	Robinette	B-Reader	9/27/02	1	2/2; q/t
CX 1	Cappiello	B-Reader/ BCR	9/27/02	1	2/2; p/p
EX 3	Scatarige	B-Reader/ BCR	9/27/02	1	No CWP or silicosis

Pulmonary Function Studies

Ex. No.	Physician	Date of Study	Conforming?	Qualifying?	Age/ Height	FEV_1	FVC	MVV	Coop./ Comp.
EX 5	Zaldivar	1/9/02	Yes	Yes Yes	48 yrs./ 71 in.	1.98 2.15	4.16 4.34	78 83	Not noted
DX 12	Forehand	1/16/02	Yes	Yes Yes	48 yrs./ 70 in.	1.81 1.98	3.50 3.74	81.35 90.49	Not noted
DX	Robinette	9/27/02	Yes	Yes	49 yrs./	1.42	2.91		Not noted

[2] Section 725.414(a)(3)(i) allows the Employer no more than two chest x-ray interpretations in support of its affirmative case. According to its Evidence Summary Form, dated January 11, 2005, Employer submitted one chest x-ray interpretation, designated EX 1, conducted by Dr. Bob W. Gaylor and dated January 9, 2002, in support of its case. Employer also submitted a chest x-ray interpretation, designated EX 3, conducted by Dr. John C. Scatarige and dated September 27, 2002, in support of its case. Section 725.414(a)(3)(ii) allows the Employer no more than one chest x-ray interpretation to rebut the chest x-ray provided to Claimant by the Director. According to its Evidence Summary Form, Employer filed one chest x-ray interpretation, designated EX 4, conducted by Dr. Paul S. Wheeler and dated January 16, 2002, to rebut the Director's chest x-ray interpretation. Section 725.414(a)(2)(i) allows the Claimant no more than two chest x-ray interpretations in support of its affirmative case. Claimant submitted a chest x-ray interpretation, conducted by Dr. Emory Robinette and dated January 9, 2002, designated DX 36, in support of its case. Claimant also submitted a chest x-ray interpretation, conducted by Dr. Enrico Capiello and dated September 27, 2002, designated CX 1, in support of its case. Section 725.406(a) requires the Department of Labor to provide a complete pulmonary evaluation including chest x-ray interpretation to each miner who applies for benefits. In this case, Dr. Forehand provided a chest x-ray interpretation, dated January 16, 2002 and designated DX 15.

[3] "BCR" refers to a board-certified radiologist. B-reader qualifications are recorded on the B-reader List published on DOL's website. *List of Approved B-Readers* (June 21, 1999), *at* http://www.oalj.dol.gov/public/blalung/refrnc/bread3.htm. Board-Certification is reflected in the listings by the American Board of Medical Specialties ("ABMS"). *American Board of Medical Specialties*, *at* abms.org. Judicial notice has been taken of these resources if the qualifications of the physicians are not otherwise of record. *See Maddaleni v. Pittsburg & Midway Coal Co.*, 14 BLR 1-135 (1990).

Ex. No.	Physician	Date of Study	Conforming?	Qualifying?	Age/ Height	FEV_1	FVC	MVV	Coop./ Comp.
36				Yes	70 in.	1.67	3.32		

Blood Gas Studies

Ex. No.	Physician	Date of Study	Qualifying?	Altitude	Resting(R) Exercise(E)	PCO_2	PO_2	Comments
EX 5	Zaldivar	1/9/02	No	0-2999	R E	29 36	104 68	None
DX 11	Forehand	1/16/02	No No	0-2999	R E	36 38	88 69	None
DX 36	Robinette	9/27/02	No	0-2999	R	29	119	None

CT Scan Readings

Ex. No.	Physician	Date of Study	Comments
EX 6	Wheeler	10/8/98	No pneumoconiosis; No complicated pneumoconiosis
EX 6	Scott	10/8/98	Pneumoconiosis highly unlikely
EX 6	Wheeler	4/2/02	No pneumoconiosis
EX 6	Wheeler	9/9/04	No pneumoconiosis

Physicians' Opinions and Depositions

1) Physician Opinion of Dr. J. Randolph Forehand

Dr. Forehand conducted a medical examination of Claimant on January 16, 2002, which included taking appropriate medical and social histories, performing a physical examination and clinical tests. DX 10. In documenting his medical examination, Dr. Forehand used Department of Labor Form CM-988.

Dr. Forehand recorded that the patient had a negative medical history. *Id.* at 2. He stated that Claimant reported smoking at age 32. Claimant smoked a pack of cigarettes per day for 7 to 8 years. At the time of examination, Claimant reported daily sputum, dyspnea for about 8 years from any kind of exertion, and orthopnea.

Dr. Forehand summarized the diagnostic tests. *Id.* at 3. He recorded that Claimant's chest x-ray showed pneumoconiosis. The pulmonary function test demonstrated an obstructive ventilatory pattern. Claimant's arterial blood gas studies showed no significant hypoxemia at rest or with exercise, and no metabolic disturbance. An EKG found normal tracing.

Dr. Forehand concluded from Claimant's history, his physical examination, and pulmonary function studies that Claimant had pneumoconiosis and chronic bronchitis. Id at 4. He opined that the causes were coal dust exposure and cigarette smoking. Dr. Forehand stated that the degree of respiratory impairment is significant. He noted that Claimant had insufficient residual ventilatory capacity, which continued from his last coal mining job. Dr. Forehand indicated that Claimant was unable to work, and was totally and permanently disabled. He opined that pneumoconiosis contributes to Claimant's significant impairment of the lung function to a greater extent than chronic bronchitis. Dr. Forehand stated that this is apparent on chest x-rays, in physical examination, and in spirometry. He opined that cigarette smoking for 7 years would not impair Claimant's lung function to the degree seen on his objective tests, the x-rays and spirometry.

2) Physician Opinion of Dr. George L. Zaldivar

Dr. Zaldivar conducted a medical examination of Claimant on March 11, 2002, which included taking appropriate medical and social histories, clinical tests and a physical examination. EX 5. Dr. Zaldivar is board-certified in internal medicine and pulmonary diseases. He also reviewed specified medical records of Claimant provided to him. *Id.* at 1-2.

Dr. Zaldivar noted that the Occupational Pneumoconiosis Board, in its September 22, 1998 report, found 15% impairment due to pneumoconiosis. *Id.* at 1. The Occupational Pneumoconiosis Board's report is in the record, designated DX 8. He stated that Claimant was 45 years old at the time and had 27 years of experience as a coal miner. Claimant indicated that he had been short of breath and had a chronic cough with sputum for five years. Dr. Zaldivar stated that a chest x-ray showed "interval changes in the right, mid and upper lung zones." He opined that there was no convincing evidence of pneumoconiosis.

After reviewing Claimant's medical documents, Dr. Zaldivar made four medical findings. *Id.* at 2. He diagnosed Claimant with moderate irreversible airway obstruction, air trapping by lung volumes, moderate diffusion impairment, and moderate pulmonary limitation to exercise. Dr. Zaldivar noted the following:

> When I interpreted the chest x-ray I thought the masses that were seen were the result of old granulomas. However, the report from the Occupational Pneumoconiosis Board of 9/22/1998 makes no mention of any masses in the lungs. They did notice an ill defined density beginning to show at that time.

Dr. Zaldivar stated that Claimant had a history of smoking from his thirties until eight to ten years prior to his evaluation. However, he opined that the degree of bullous emphysema seen radiographically is most compatible with that of an individual who smoked over 20 pack years of cigarettes and is susceptible to the effects of tobacco. Dr. Zaldivar stated that pneumoconiosis does not cause bullous emphysema.

He concluded that, based on all of the information, Claimant does not have pneumoconiosis or other dust disease of the lungs. Dr. Zaldivar opined that Claimant's bullous emphysema is more logically attributed to smoking. He noted that Claimant has a mass in his

lung which has appeared since 1998 and needs to be investigated for possible cancer. He also stated that Claimant's emphysema is severe enough to prevent him from performing his usual work.

Dr. Zaldivar detailed Claimant's work history. *Id.* at 4. He stated that Claimant worked in the coal mines for 25 years, up until 1997. Dr. Zaldivar noted that Claimant had been an electrician since 1975. He stated that Claimant's job included moving equipment, including power supplies, and doing electrical work and welding.

Dr. Zaldivar prepared a supplemental report, dated March 18, 2002, after reviewing additional specified medical records provided to him.[4] No physical examination of Claimant was conducted in connection with the supplemental report. After reviewing the information provided, he concluded that Claimant does not have a pulmonary impairment. *Id.* at 2. Dr. Zaldivar also concluded that Claimant does not have pneumoconiosis. He stated that there are radiological changes that have occurred since Claimant's evaluation by the Pneumoconiosis Board, but that they are not related to pneumoconiosis and may represent cancer or an infection.

3) Physician Opinion of Dr. Vishnu Patel

Dr. Patel conducted a medical examination of Claimant on June 25, 2002, which included taking appropriate medical and social histories, clinical tests and a physical examination. DX 35. He noted that Claimant had significant dyspnea on exertion and a significant cough with expectorations. Dr. Patel stated that Claimant underwent a bronchoscopy and transbronchial biopsy, which showed no evidence of tuberculosis ("TB") or malignancy. There were no granuloma evident.

Dr. Patel noted that the medical history included chronic obstructive pulmonary disease ("COPD") and pneumoconiosis. He stated that Claimant denied any history of diabetes, TB, myocardial infarctions, or cancers in the body. Dr. Patel reported that Claimant worked in coal mines for twenty-five years, ending his employment in 1996. According to Claimant, he smoked cigarettes for about 7 to 8 years, stopping in 2000. Claimant denied alcohol or drug use.

Dr. Patel conducted a physical examination. He examined Claimant's lungs, finding bilateral decreased air entry, but no crackles or wheezing. Dr. Patel also reviewed specified medical records. He stated that Claimant had bilateral upper lobe densities compatible with progressive, massive fibrosis. *Id.* at 2. Dr. Patel reviewed two chest x-rays, dated February 10, 1997 and February 22, 2002, finding an opacity in the right upper lung field and abnormalities in the right upper and middle lung field. He reviewed Claimant's spirometry, noting that it evidenced moderate respiratory impairment. Dr. Patel also analyzed Claimant's arterial gas studies, stating that Claimant had a significant reduction in oxygenation.

[4] In Dr. Zaldivar's March 18, 2002, report, he reviews additional medical records of Claimant, which could have been expected to have been reviewed in his first report, convenience permitting. He did not conduct another physical examination. As a result, his report is deemed to be supplemental to, and effectively part of, his original March 11, 2002, report, and not a separate report. Therefore, Employer has submitted two physicians' opinions and adhered to the evidentiary limitations of § 725.414(a)(3)(i).

Dr. Patel made several conclusions. He noted that Claimant had significant occupational exposure, very little smoking history, and no history of TB. Dr. Patel also opined that the CT scan, x-ray, arterial blood gas, pulmonary function study and cardiopulmonary exercise evidence was all consistent with significant respiratory impairment. He opined that the CT scan findings were highly suggestive of progressive, massive fibrosis, consistent with complicated pneumoconiosis.

4) Physician Opinion of Dr. Emory Robinette

Dr. Robinette conducted a medical examination of Claimant, dated October 14, 2002, which included taking appropriate medical and social histories, clinical tests and a physical examination. DX 36. Claimant complained of shortness of breath, cough, congestion, dyspnea, and chronic sputum production.

Claimant stated that he worked in the mining industry for more than 25 years, last working in 1997. He reported working for approximately 14 years as a continuous miner operator and subsequently as an electrician and welder for the remainder of his employment. Dr. Robinette noted that Claimant stopped smoking approximately 10 years before the examination. *Id.* at 2. He smoked less than 6 pack years and typically smoked less than one pack of cigarettes per day.

Dr. Robinette summarized the diagnostic testing. He interpreted a chest x-ray, taken September 27, 2002. *Id.* at 3. He found evidence of coalescence of the interstitial opacities in the upper lung zones. Dr. Robinette noted that there were diffuse opacities consistent with pneumoconiosis. He read the x-ray as q/t, 2/2. He found that nonspecific pleural thickening was present. Dr. Robinette also conducted pulmonary function studies, arterial blood gas tests, and an EKG. He stated that the blood gas tests and EKG readings were normal.

Dr. Robinette concluded that Claimant has complicated pneumoconiosis with underlying progressive massive fibrosis, very severe airflow obstruction, and chronic bronchitis. He stated that Claimant's medical history is complicated by a prior diagnosis of pneumonia. He noted that biopsies were not diagnostic of TB or malignancy. Dr. Robinette reviewed Dr. Forehand's opinion and stated that Dr. Forehand "felt that the patient had evidence of coal workers' pneumoconiosis based on radiographic abnormalities and had insufficient residual ventilatory capacity to perform the duties of an underground coal miner and was totally disabled from working."

Dr. Robinette stated that he read medical records of Claimant from Dr. Zaldivar and Dr. Forehand. *Id.* at 4. After reviewing these records, he again concluded that Claimant has complicated pneumoconiosis with progressive massive fibrosis. Dr. Robinette opined that his functional impairment is severe, such that he is totally disabled from working, "even according to Social Security guidelines." He continued that Claimant's condition appears to be chronic and progressive in nature. Dr. Robinette asserted that Claimant had a significant loss of lung function over the previous 12 months.

5) Deposition of Dr. Paul S. Wheeler[5]

Dr. Wheeler gave a telephone deposition on January 5, 2004. EX 7. He explained that he reviewed chest x-ray interpretations and CT scans in diagnosing Claimant. *Id.* at 9. Dr. Wheeler declared that CT scans are better than routine chest x-rays. He stated that in his opinion, "CT scanning was more accurate than plain film analysis, particularly when NIOSH only requires you to have a single PA view." Dr. Wheeler stated that CT scans are superior to x-rays in that they give cross sectional views of the lungs as opposed to frontal views, lateral views, or oblique views. *Id.* at 10. Because of the cross sectional analysis, no lung detail is hidden. According to him, a January 9, 2002, x-ray showed a 3 cm by 7 cm mass in the lateral portion of Claimant's right upper lobe and a 5 cm by 2.5 cm mass in the left upper lobe. *Id.* at 12. In Dr. Wheeler's opinion, this was "compatible with conglomerate tuberculosis." He read a January 16, 2002, x-ray, finding similar extensive infiltrates or fibrosis in the right upper lobe. Dr. Wheeler's findings in reading x-rays taken September 27, 2002 and September 9, 2004 were similar. *Id.* at 13. He stated that a CT scan showed an 8 cm mass in the right upper lobe and a 6 cm mass in the left upper lobe.

Dr. Wheeler opined that the pleural involvement is important because pneumoconiosis and silicosis typically create small nodules in the central portion of the upper lobes. The nodules are not in the periphery and do not involve the pleura. Dr. Wheeler next explained the three CT scans he administered. *Id.* at 14. On a chest CT scan taken September 9, 2004, he found calcified granulomata in the upper lobes, which could be from TB or histoplasmosis. *Id.* at 15. Dr. Wheeler also noted moderate emphysema and areas of decreased and distorted lung markings, presumably due to cigarette smoking. According to him, a chest CT scan taken April 4, 2002 showed focal arteriosclerosis proximal left coronary artery, but not pneumoconiosis. *Id.* at 15. Dr. Wheeler found calcified granulomata in Claimant's left upper lobe, which he opined was compatible with conglomerate TB. *Id.* at 16. He stated that an October 8, 1998, chest CT scan showed emphysema in the right apex, small subpleural blebs in the right upper lobe and some areas of decreased and distorted lung marking. *Id.* at 17. Dr. Wheeler found no evidence of silicosis or pneumoconiosis.

Dr. Wheeler stated that it is unusual for someone in Claimant's age group to develop large opacities. *Id.* at 22. Claimant was 53 years old at the time of the deposition. Dr. Wheeler noted that the large opacities he had seen in his career typically involved coal miners working without respiratory protection. Often, he testified, the workers were drillers working unprotected during and before World War II.

On cross-examination, Dr. Wheeler indicated that the symptoms of TB include fever, cough, and occasionally, weight loss. *Id.* at 23. He opined that Claimant had TB that healed in his apices in 1998 and stated that an x-ray showed an advanced disease on January 9, 2002. *Id.* at 24. Dr. Wheeler indicated that pneumoconiosis is typically a gradual onset phenomenon. He

[5] Section 725.414(c) allows a party submitting fewer than two medical reports as part of its affirmative case to offer a physician's testimony in lieu of a medical report. The physician's testimony shall be considered a medical report for purposes of the evidentiary limitations of § 725.414. Because Employer submitted only one medical report as part of its affirmative case, Dr. Wheeler's deposition testimony is admissible under § 725.414(c) as a separate medical report.

asserted that an individual with TB does not necessarily have symptoms. *Id.* at 25. Dr. Wheeler noted that a person with TB can walk around, and that activity, in fact, spreads the disease.

Dr. Wheeler explained that there are people with advanced TB who do not develop a Tyne test. *Id.* at 26. He indicated that when a person has advanced TB, the body will not use its immune reaction on a skin test because it is handling the direct infection in the lung.

On redirect examination, Dr. Wheeler stated that giant cell arteritis is an inflammatory disease that can perfectly mimic TB in that there are similar symptoms. Id at 27-28. However, it is not an infection but autoimmune, such that the body develops antibodies against its own tissue. *Id.* at 28. Giant cell arteritis, in Dr. Wheeler's experience, is not curable.

On subsequent cross-examination, Dr. Wheeler stated that Claimant's linear scarring in his apices is typical of minimally healed TB. *Id.* at 29. On subsequent redirect examination, Dr. Wheeler stated that Claimant's opacities are not from coal dust exposure. *Id.* at 31. He was highly certain that Claimant had a granulomatous disease, mostly likely TB given the pattern in the specific location.

DISCUSSION AND CONCLUSIONS OF LAW

To be eligible for benefits, Claimant must show, by a preponderance of the evidence, that he is a coal miner, has pneumoconiosis that arose out of coal mine employment, is totally disabled, and that the pneumoconiosis contributed to the total disability. § 725.202(d). Claimant's employment and Social Security records indicate that his coal mine employment totaled approximately 18 years. DX 5. Claimant's status as a coal miner is not at issue. However, Employer disputes that it is the responsible operator.

Responsible Operator

As a threshold issue, Employer argues that it should not be the named responsible operator with respect to this claim. Emp. Cl. Arg. at 23. Under § 725.465(b), an "administrative law judge shall not dismiss the operator designated as the responsible operator by the district director, except upon the motion or written agreement of the Director." In its comments, the Department of Labor stated:

> The revised regulation is intended to . . . ensure that the designated responsible operator and the Director have the opportunity to fully litigate the liability issue at all levels. Moreover, the regulation does not create any undue hardships. If, after considering all of the evidence relevant to the responsible operator issue, the ALJ finds that the designated responsible operator is not liable for the payment of benefits, but concludes that the claimant is entitled to benefits, the operator merely has to wait until the Director, on behalf of the Trust Fund, files an appeal with the BRB. The operator may then participate in that appeal in defense of the ALJ's liability determination if it wishes. If the Director does not petition for review of the ALJ's liability decision, the operator need not participate in any further adjudication of the case, regardless of whether it is formally included as a party.

Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 80,005 (Dec. 20, 2000). If multiple operators are listed on referral from the district director, the comments to the regulations state that the administrative law judge would be permitted to dismiss the operators at any time. 65 Fed. Reg. 80,004 (2000). The plain language of §725.418(d), however, requires that the Director consent to such dismissals.

In its comments to the amended regulations, the Department of Labor also made clear that an administrative law judge is not empowered to remand a claim for designation of an operator:

> Once all of (the) evidence is forwarded to the Office of Administrative Law Judges for a formal hearing, the administrative law judge assigned to the case will determine, in light of the evidentiary burdens imposed by section 725.495, whether the district director designated the proper responsible operator. If the administrative law judge determines that the district director did not designate the proper responsible operator, liability will fall on the Trust Fund. No remand for further development of the responsible operator issue is permissible.

Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 80,008 (Dec. 20, 2000).

As a matter of law, Employer was properly designated as the responsible employer. Under § 725.495, an operator may be considered a "potentially liable operator" with respect to benefits under the Act if the miner was employed by operator for more than a year. Section 725.495(a)(1) states that responsible operator shall be the potentially liable operator. Claimant's Social Security records demonstrate that Claimant worked for Employer as a miner for more than one year. DX 5. To prove that it is not responsible for paying benefits under the Act, the designated responsible operator bears the burden of fulfilling the requirements of § 725.495(c), which include, *inter alia*, establishing that a more recent employer of the miner for more than one year "possesses sufficient assets to secure the payment of benefits." Employer has not provided any evidence of a more recent employer able to pay benefits to Claimant. Therefore, Employer has not demonstrated that it was improperly designated as the responsible operator and its contention that it should be dismissed as the responsible operator in this case is without merit.

Presence of Pneumoconiosis

Claimant must prove that he has either clinical or legal pneumoconiosis as defined in § 718.201. The regulations provide four methods for finding the existence of pneumoconiosis: properly conducted and reported chest x-rays, properly conducted and reported autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305 and 718.306, and reasoned medical opinions based upon objective evidence. § 718.202(a)(1)-(4).

In determining the probative value of chest x-ray evidence, the date of the study and the qualifications of the interpreting physicians are factors to be considered. *Wheatley v. Peabody Coal Co.*, 6 B.L.R. 1-1214 (1984); *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Pruitt v. Director, OWCP*, 7 B.L.R. 1-544 (1984). Drs. Gaylor, Wheeler, and Scatarige, all dually-

certified physicians, provided negative diagnoses for pneumoconiosis. EX 1; EX 3; EX 4. On the other hand, Dr. Cappiello was the only dually-certified physician to interpret an x-ray as positive. Drs. Forehand and Robinette, who interpreted chest x-rays as positive, 2/2, are both B-readers. The physicians finding no radiographic evidence of pneumoconiosis are slightly more qualified than those finding a positive reading, but there is also strong positive evidence of pneumoconiosis. Taking these determinations into account, the available x-ray evidence is in equipoise as to the existence of pneumoconiosis.

There is not sufficient evidence which proves the existence of complicated pneumoconiosis. Therefore, Claimant is not entitled to the presumption in § 718.304. Dr. Patel's opinion noted that a CT scan reading was highly suggestive of progressive, massive fibrosis consistent with complicated pneumoconiosis. However, he did not cite any other diagnostic evidence, such as chest x-rays showing opacities larger than 1 cm or biopsy or autopsy evidence of massive lesions, supporting his opinion that Claimant has complicated pneumoconiosis. Furthermore, the CT scan evidencing complicated pneumoconiosis referenced by Dr. Patel is not part of the record. Section 718.107(a) allows any medically acceptable test or procedure reported by a physician and not addressed in Part 718, such as CT scans, to be submitted in connection with a claim. However, § 718.107(b) places a burden on the party submitting the test to demonstrate that the test or procedure is medically acceptable and relevant to establishing or refuting a claimant's entitlement to benefits. There is no evidence submitted by Claimant demonstrating that CT scans are medically acceptable or relevant establishing or refuting his entitlement to benefits.

Similarly, Dr. Robinette made the conclusory statement that Claimant has complicated pneumoconiosis, as well as progressive massive fibrosis, very severe airflow obstruction, and chronic bronchitis. However, he did not cite any other diagnostic evidence or medical reasons supporting his diagnosis that Claimant has complicated pneumoconiosis. As a result, there is not sufficient objective or medical opinion evidence to support a finding that Claimant has complicated pneumoconiosis.

The claim was filed after 1982, and so Claimant is not entitled to the presumption in § 718.305. Because this is not a claim for survivor's benefits, the presumption in § 718.306 does not apply. Therefore, Claimant cannot establish the presence of pneumoconiosis through the presumptions in §§ 718.304, 718.305 or 718.306.

Dr. Forehand's medical opinion is a reasoned one. DX 10. He relied on the diagnostic tests available, his physical examination, and Claimant's history in diagnosing pneumoconiosis. The chest x-ray evidence, as interpreted by Dr. Forehand, showed pneumoconiosis, while the spirometry evidenced an obstructive ventilatory pattern. Dr. Forehand also took Claimant's 7 year smoking history into consideration in making his medical conclusions. For these reasons, Dr. Forehand's opinion is of substantial probative value.

Dr. Zaldivar's opinion contains some inconsistencies, is not supported by objective tests, and relies on inadmissible evidence. EX 5. Dr. Zaldivar noted that he interpreted a chest x-ray, although he did not provide a date, so that it is unclear which x-ray he read. *Id.* at 2. He noted large masses in the lungs, opining that they are the result of old granulomas, not pneumoconiosis.

He did not further explain this finding, only stating that an Occupational Pneumoconiosis Board report, dated September 22, 1998, found no mention of any lung masses. Dr. Zaldivar's apparent implication is that the masses present in Claimant's lungs could not have been due to pneumoconiosis, because they developed after 1998. However, he did note that the Occupational Pneumoconiosis Board found "an ill defined density beginning to show at that time." Dr. Zaldivar did not record a conclusion as to the cause of this density. In addition, the Occupational Pneumoconiosis Board report constitutes a medical opinion, as it included a review of medical reports, a physical examination, and the medical diagnoses of three physicians. The report was not designated by either party and would exceed of the evidentiary limitations of § 725.414. Therefore, Dr. Zaldivar's consideration of the Occupational Pneumoconiosis Board report was improper and inadmissible. Furthermore, it undermines any analyses made by Dr. Zaldivar based on the report.

In his supplemental report, written one week later, Dr. Zaldivar opined that the cause of the radiological changes in Claimant were possibly a result of cancer or an infection. This diagnosis is apparently inconsistent with Dr. Zaldivar's first opinion regarding Claimant's lung masses, that they are old granulomas unrelated to pneumoconiosis. Dr. Zaldivar also opined that Claimant has bullous emphysema, opining that the extent of his bullous emphysema visible on x-ray is more compatible with an individual with over 20 pack years of smoking cigarettes. However, he cited no further evidence that Claimant misled him about his smoking history, which Claimant has consistently maintained is approximately 7 or 8 years. None of the other physicians' opinions disputed Claimant's reported smoking history. Furthermore, of the physicians, only Dr. Wheeler opined that Claimant has "moderate emphysema."

Dr. Zaldivar's medical opinion is also inconsistent as to whether Claimant is impaired from a pulmonary standpoint. In his March 11, 2002, report, he opined that Claimant had emphysema severe enough to prevent him from his usual work. Dr. Zaldivar, in his supplemental report, noted that Claimant does not have a pulmonary impairment. These two statements are contradictory as to a significant material fact and seriously impair the credibility of Dr. Zaldivar's opinion. Because of the inconsistencies within Dr. Zaldivar's diagnoses, a lack of objective evidence, and reliance on inadmissible evidence, his opinion is not persuasive.

Dr. Patel's medical conclusions are based on Claimant's medical history and occupational history, but much of the diagnostic testing he relied upon is inadmissible. DX 35. Dr. Patel noted no crackles or wheezing, but found bilateral upper lobe densities. In reading two chest x-rays, dated February 10, 1997 and February 22, 2002, he found an opacity in Claimant's right upper lung field and abnormalities in the right upper and middle lung field. However, these x-ray interpretations are inadmissible, as neither was designated by a party and would exceed the evidentiary limitations of § 725.414(a)(2)(i). Dr. Patel also stated that Claimant had a history of COPD and pneumoconiosis. He ruled out TB, as he noted that Claimant has no history of that disease.

Dr. Patel noted that a CT scan was highly suggestive of progressive, massive fibrosis, consistent with complicated pneumoconiosis. However, the CT scan evidence is also inadmissible under § 718.107. Section 718.107(b) places a burden on the party submitting the test to demonstrate that the test or procedure is medically acceptable and relevant to establishing

or refuting a claimant's entitlement to benefits. In this case, neither Dr. Patel nor Claimant has submitted evidence that CT scans are medically acceptable and relevant to establishing or refuting pneumoconiosis or entitlement to benefits. As a result, any references to CT scan evidence in Dr. Patel's opinion are inadmissible.

Dr. Patel also relied upon the length of Claimant's coal mine employment in concluding that Claimant has pneumoconiosis. Dr. Patel stated that Claimant had 25 years of coal mine work experience when this tribunal has found that he worked in the mines for approximately 18 years. This inaccuracy further undermines Dr. Patel's analysis.

Dr. Patel's diagnosis relies heavily upon x-ray and CT scan evidence that is inadmissible. Without that diagnostic test evidence, his medical conclusion that Claimant has pneumoconiosis is not well-supported by the medical testing. Dr. Patel's opinion does not refer to any other admissible objective testing in support of his diagnosis of complicated pneumoconiosis. Therefore, because his opinion that Claimant has pneumoconiosis is based almost entirely on inadmissible evidence, Dr. Patel's opinion is inadmissible as to whether Claimant has pneumoconiosis. As a result, it will not be considered in determining the presence or absence of pneumoconiosis.

Dr. Robinette noted that the chest x-rays he interpreted evidenced interstitial opacities in the upper lung zones and diffuse opacities consistent with pneumoconiosis. DX 36. He also stated that the biopsy evidence showed no TB. He properly took Claimant's smoking history into account in making his diagnosis. Dr. Robinette also reviewed the medical records of Drs. Zaldivar and Forehand in arriving at his medical conclusion that Claimant has pneumoconiosis. He did overstate Claimant's coal mine work experience as 25 years, but properly relied upon available objective testing, chest x-rays and biopsy evidence, in making his conclusions. As a result, his medical opinion is credible and entitled to substantial probative weight.

Dr. Wheeler found large opacities in the left and right upper lobes of Claimant's chest. EX 7. Dr. Wheeler opined that Claimant's opacities are not from coal dust exposure, but from TB or histoplasmosis. He stated that pneumoconiosis typically creates small nodules in the central portion of the upper lobes of the lung, not large opacities. He stated that it is unusual for a person of Claimant's age, 53 years old, to develop large opacities. He later opined that large opacities are rare unless coal miners have been working without respiratory protection as in the World War II era. In addition, Dr. Wheeler did not explain his finding of large opacities, but found no pneumoconiosis in the January 16, 2002, chest x-ray.

Dr. Wheeler repeatedly opined that the masses found in Claimant's upper lungs were a result of TB, but cited little medical evidence for that conclusion. He only opined that Claimant's linear scarring in his apices is typical of minimally healed TB, but cited no evidence that Claimant had been diagnosed with the disease prior to the deposition. Dr. Wheeler's contention that Claimant had TB is not supported by the other medical evidence. None of the other physicians' opinions found a history or evidence of TB. Dr. Patel noted that a bronchoscopy and transbronchial biopsy showed no evidence of TB. Dr. Robinette also cited biopsy evidence in opining that Claimant did not have TB.

Dr. Wheeler's opinion relied on four interpretations of chest x-rays, taken January 9, 2002, January 16, 2002, September 27, 2002, and September 9, 2004. The September 9, 2004, x-ray is not part of the record in this case, and is inadmissible. Because Dr. Wheeler's testimony related to it is essentially cumulative, his reference to it does not preclude consideration of his opinion. Dr. Wheeler's reference to a 1998 x-ray is of similar effect. In the three admissible x-rays, Dr. Wheeler noted large masses in the left and right upper lobes. However, he opined that these masses were attributable to causes other than pneumoconiosis, such as conglomerate TB and fibrosis. Dr. Wheeler made this finding which is inconsistent with the fact that the x-ray taken January 16, 2002 was read as positive for pneumoconiosis by Dr. Forehand and the September 27, 2002, x-ray was read as positive by Drs. Robinette and Cappiello.

Dr. Wheeler also relied on numerous CT scans in determining that Claimant's lung masses were attributable to TB, histoplasmosis, or emphysema. EX 6. However, pursuant to § 718.107(b), Employer bears the burden of demonstrating that the test or procedure is medically acceptable and relevant to establishing or refuting Claimant's entitlement to benefits. Dr. Wheeler stated that CT scans are superior to chest x-rays in that they give cross sectional views of the lungs as opposed to frontal views, lateral views, or oblique views, evidence of the relevance of CT scans in establishing or refuting pneumoconiosis. EX 7 at 9-10. However, neither Employer nor Dr. Wheeler put forth evidence that CT scans are medically acceptable. As a result, any references to CT scan evidence in Dr. Wheeler's opinion are inadmissible or are not properly considered.

Many of the medical conclusions made by Dr. Wheeler are based upon inadmissible evidence or are unsupported by other medical evidence. Dr. Wheeler is the only physician who concluded that Claimant had a history of TB. Dr. Patel stated that bronchoscopy and biopsy evidence showed no evidence of TB. DX 35. Similarly, Dr. Robinette noted that the biopsies were not diagnostic of TB. DX 36. Also, Dr. Wheeler's reading of the chest x-rays in this case is contradicted to some extent by Drs. Forehand, Robinette, and Cappiello. None of the CT scan evidence he relies upon is admissible. Also, one of the chest x-rays cited by Dr. Wheeler is inadmissible. Without the largely discredited conclusions Dr. Wheeler draws from this diagnostic testing, his diagnoses are based upon little objective evidence in the record. Although Dr. Wheeler relies to an extent on inadmissible evidence, he does cite sufficient chest x-ray evidence such that his opinion is not wholly inadmissible as to whether Claimant has pneumoconiosis. However, because he relies heavily upon inadmissible evidence and his own unsupported conclusions, Dr. Wheeler's opinion is given relatively little probative weight.

Overall, the opinions finding the presence of pneumoconiosis, written by Drs. Forehand, Patel, and Robinette, are more persuasive than the negative opinions of Drs. Zaldivar and Wheeler. Drs. Forehand and Robinette made their reasoned conclusions, properly based on the available, admissible objective evidence. Dr. Patel's opinion is inadmissible and properly was not considered. Dr. Zaldivar's opinion was contradictory, as he found that the Claimant was unable to return to work due to his emphysema, but later opined that Claimant does not have a pulmonary impairment. Also, his statement that Claimant has bullous emphysema is largely contradicted by the other physician opinion evidence. Dr. Wheeler gave contradictory statements as to whether large opacities, such as those found in Claimant's lungs, are evidence of pneumoconiosis. He also relied on inadmissible CT scan evidence and x-ray evidence. Taken as

a whole, the physician opinions, by a preponderance of the evidence, demonstrate that Claimant has legal pneumoconiosis, chronic lung disease or impairment arising out of coal mine employment, as defined under § 718.201(a)(2). Therefore, Claimant has proven the existence of pneumoconiosis as allowed under § 718.202.

Employer argues that the negative CT scan is evidence that Claimant does not have pneumoconiosis. Employer Closing Argument ("Emp. Cl. Arg.") at 20; EX 6. It should be noted that while a CT scan is probative, the Department of Labor has rejected the view that a CT scan, by itself, "is sufficiently reliable that a negative result effectively rules out the existence of pneumoconiosis." 65 Fed. Reg. 79,920, 79,945 (Dec. 20, 2000). The rational for this view is that the "statutory definition of 'pneumoconiosis' ... encompasses a broader spectrum of diseases than those pathological conditions which can be detected by clinical diagnostic tests such as x-rays or CT scans." *Consolidation Coal Co. v. Director, OWCP*, 294 F.3d 885, 890 (7th Cir. 2002). In addition, the CT scan evidence Employer cites is inadmissible under § 718.107 and is not part of the record. Employer has not submitted any evidence that CT scans are medically acceptable and relevant to establishing or refuting the presence of pneumoconiosis.

Causation

Claimant must show that his pneumoconiosis arose out of coal mine employment. § 725.202(d)(2)(ii). A Claimant with pneumoconiosis, employed for ten years or more in one or more mines, is entitled to a rebuttable presumption that the pneumoconiosis arose out of such employment. § 718.203(b); § 718.302. Claimant has a history of approximately 18 years of coal mine employment and has demonstrated the existence of pneumoconiosis. Employer has not submitted any evidence that the cause of Claimant's pneumoconiosis was a source other than coal mine dust exposure. Therefore, Employer has not rebutted the presumptions set forth in § 718.203(b) and § 718.302, such that Claimant has shown that he has pneumoconiosis resulting from his coal mine employment.

Total Disability

Under § 725.202(d)(2)(iii), Claimant must establish that he is "totally disabled" to be eligible for benefits. Section 718.204(b) defines "total disability" as follows:

> A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:
>
> (i) From performing his or her usual coal mine work; and
>
> (ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time.

Claimant may prove total disability by qualifying pulmonary studies, qualifying arterial blood gas studies, or the reasoned medical judgment of a physician, based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(a)(2).

The pulmonary function tests of record establish total disability as set forth in § 718.204(b)(2) and Appendix B to Part 718. The pulmonary function tests conducted on Claimant were qualifying and thus establish that Claimant is totally disabled. EX 5; DX 12; DX 36.

The physician opinion evidence, as a whole, also establishes total disability. Dr. Forehand opined that Claimant was unable to work, and totally and permanently disabled. DX 10. Dr. Robinette opined that Claimant's functional impairment is so severe that he is totally disabled from working, "even according to Social Security guidelines." DX 36. Dr. Patel stated that the diagnostic testing was "consistent with significant respiratory impairment," implying that Claimant is totally disabled. DX 35. Dr. Zaldivar opined that Claimant's emphysema was "severe enough to prevent him from performing his usual work," a finding that by definition deems Claimant totally disabled under § 718.204(b). EX 5. Dr. Wheeler did not give an opinion as to total disability. Because the physician evidence as a whole supports a finding of total disability, and there is no medical opinion evidence, except Dr. Zaldivar's inconsistent supplemental opinion, against total disability, and the pulmonary function tests indicate total disability, by a preponderance of the evidence, Claimant is totally disabled.

Total Disability due to Pneumoconiosis

Under § 725.202(d)(2)(iv), Claimant must establish that pneumoconiosis contributes to total disability to be eligible for benefits. Dr. Forehand addressed the issue, noting that Claimant is permanently and totally disabled, and that pneumoconiosis contributes to Claimant's significant impairment of the lung function. DX 10. Dr. Robinette opined that Claimant has complicated pneumoconiosis and that his resulting "functional impairment is severe." DX 36. Dr. Zaldivar attributed Claimant's total disability to emphysema. EX 5. Dr. Patel noted significant occupational exposure to coal dust in opining that Claimant has "significant respiratory impairment." DX 35. It has been established that Claimant's past coal mine employment caused his pneumoconiosis. The physician opinions, as a whole, with regards to the cause of Claimant's total disability, establish that it is attributable, at least in significant part, to pneumoconiosis. Dr. Zaldivar's opinion that Claimant has emphysema, causing his total disability, has been contradicted by most of the other physician opinion evidence. Therefore, the preponderance of the evidence shows that Claimant's pneumoconiosis contributed to his total disability.

COMMENCEMENT OF ENTITLEMENT TO BENEFITS

Since the evidence does not establish the month of onset of total disability due to pneumoconiosis arising out of coal mine employment, benefits shall commence effective May 1, 2001, beginning with the month during which the miner filed his claim. § 725.503(b).

ATTORNEY'S FEES

Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to §725.365 and §725.366 of the regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany

the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of Claimant, Roy Michael Vest for benefits under the Act is granted. Employer, Eastern Associated Coal Corporation, shall pay to Claimant all benefits to which he is entitled under the Act, as heretofore specified, commencing as of May 1, 2001. Employer shall reimburse the Secretary of Labor for payments made under the Act to Claimant, if any, and deduct such amount, as appropriate, from the amount it is ordered to pay pursuant to this order.

A

Edward Terhune Miller
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes final.